ASTHMA VISIT DOCUMENTATION FORM

Name: _____ Date: _____

History number: _____ Peak flow personal best: _____

CLASSIFICATION (circle appropriate category)

	1: Mild intermittent	2: Mild persistent	3: Moderate persistent	4: Severe persistent
Quick-acting medication	≤ 2 times/week	3 to 6 times/week	Daily	All the time
Night-time waking	≤ 2 times/month	3 to 4 times/month	≥ 5 times/month	Frequent
Symptoms interference	None unless with attack	Only with lots of activity	Only with moderate activity	With any activity
FEV_1, PEF (% pred.)	≥ 80 percent	≥ 80 percent	> 60 percent, < 80 percent	≤ 60 percent

Type of visit: Acute / Follow-up / Educational

BP: _____

Ht/Wt: _____

Pulse: _____ O_2 Sat: _____

RR: _____

Days with Sx (#/wk): _____

Current severity score: 1 2 3 4

Triggers: _____

Social issues: _____

_____

_____

Tobacco exposure: _____

ED since last visit? Y N Dates: _____

Hospitalizations since last visit? Y N Dates: _____

Bronchodilator: _____

Controller: _____ Other: _____

Peak flow: Pre: _____ Post: _____ Triggers this visit: _____

History: _____

_____

Pertinent ROS: Derm: _____ GI: _____ ENT: _____ Other: _____

Physical exam: HNT: _____

CV: _____

Pulm: _____ Wheezes: _____

GI: _____ I:E

Other: _____

Treatment notes: _____

_____

Assessment: 1. Asthma

2.

3.

Plan: 1.

2.

3.

TEACHING

	Review / Update		Review / Update
Action plan/education:	_____	Trigger avoidance/coping:	_____
Smoke/environment:	_____	Controller meds:	_____
Peak flow:	_____	What asthma is:	_____
Use of MDI/spacer/neb:	_____	Exercise:	_____
Other:	_____	School/work issues:	_____

Planned follow-up: _____

_____

MD/PA/NP: _____

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